BIRTH TO 3 CONNECTIONS
INTAKE FORM

Date received referral:_____

SOURCE OF INTAKE REQUEST:

Name of referring person/agency:

_____

Phone: _____

FAMILY INFORMATION

Child's name: _____ Male/Female D.O.B.____/____/___

Address:_____Guardian:*(If other than parent)*_____

Mother's name: _____Father's name: _____

Address:_____Address: _____

Phone: (H)_____(W)_____Phone: (H)_____(W)_____

Directions to family's home:

_____

_____

_____

Medical Diagnosis*:(If any)*_____

Family physician:_____ Phone: _____

CONCERNS OF REFERRAL SOURCE

CONCERNS OF PARENTS

CURRENT SERVICES *(please circle)*

Childcare Services	Head Start/Early Head Start	Respite Care Program
CHIP (Children's Health Insurance Program)	Home Health Care	Shriners
Childrens's Special Health Services	Legal Aid	SSI
Easter Seals	Medicaid	Subsidized Housing
Energy Assistance & Weatherization	Medical Insurance	Support Groups
Even Start	Mental Health Counseling	TANF (Temporary Assistance for Needy Families)
Family Support Program	Parenting Classes	WIC (Woman, Infants, & Children)
Food Stamps	Preschool Services	Other (list)